

CHAPTER 14

PROVIDER REIMBURSEMENT METHODS

TABLE OF CONTENTS

<u>SECTION</u>	<u>Page</u>
A. Hospitals.	14-1
1. CHAMPUS DRG-based payment system.	14-1
a. General.	14-1
b. Applicability of the DRG system.	14-3
c. Determination of payment amounts.	14-6
2. CHAMPUS mental health per diem payment system	14-13
a. Applicability of the mental health per diem payment system.	14-13
b. Hospital-specific per diems for higher volume hospitals and units.	14-14
c. Regional per diems for lower volume hospitals and units.	14-14
d. Base period and update factors.	14-15
e. Higher volume hospitals.	14-15
f. Payment for hospital based professional services.	14-16
g. Leave days.	14-17
h. Exemptions from the CHAMPUS mental health per diem payment system.	14-17
3. Billed charges and set rates.	14-17
4. CHAMPUS discount rates.	14-18
B. Skilled Nursing Facilities (SNFs).	14-18
c. Reimbursement for Other Than Hospitals and SNFS.	14-18
D. Reimbursement of Freestanding Ambulatory Surgical Centers.	14-18
E. Reimbursement of Birthing Centers.	14-18
F. Reimbursement of Residential Treatment Centers.	14-19
G. Reimbursement of Individual Health-Care Professionals and Other Non-Institutional Health-Care Providers.	14-21
1. Allowable charge method.	14-21
2. All-inclusive rate.	14-22
3. Alternative method.	14-22
H. Reimbursement Under the Military-Civilian Health Services Partnership Program.	14-22
1. Reimbursement of institutional health care providers.	14-22
2. Reimbursement of individual health-care professionals and other non-institutional health care providers.	14-22

SECTION

Page

I.	Accommodation of Discounts Under Provider Reimbursement Methods.	14-22
1.	General rule.	14-22
2.	Special applications.	14-23
3.	Procedures.	14-23
J.	Outside the United States.	14-23
K.	Implementing Instructions.	14-23

CHAPTER 14
PROVIDER REIMBURSEMENT METHODS

A. HOSPITALS

The CHAMPUS-determined allowable **cost** for reimbursement of a hospital shall be determined on the basis of one **of** the following methodologies.

1. CHAMPUS Diagnosis Related Group(DRG)-based payment system. Under the CHAMPUS **DRG-based** payment system, payment for the operating costs of inpatient hospital services furnished by hospitals subject to the system is made on the basis of prospectively-determined rates and applied on a per discharge basis using **DRGs**. Payments under this system will include a differentiation for urban (using large urban and other urban areas) and rural hospitals and an adjustment for area wage differences and indirect medical education costs. Additional payments will be made for capital costs, direct medical education costs, and **outlier** cases.

a. General.

(1) DRGs used. The CHAMPUS **DRG-based** payment system will use the same DRGs used **in** the most recently available grouper for the Medicare Prospective Payment System, except as necessary **to** recognize distinct characteristics of CHAMPUS beneficiaries and as described in instructions issued **by** the Director, **OCHAMPUS**.

(2) Assignment of discharges to DRGs.

(a) **The** classification of a particular discharge shall be based on the patient's age, sex, principal diagnosis (that is, the diagnosis established, after study, to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed and **discharge** status. In addition, for neonatal cases (other than normal newborns) the classification shall also account for birthweight, surgery and the presence of multiple, major and other neonatal problems, and shall incorporate annual updates **to** these classification features.

(b) Each discharge shall be assigned to only one DRG regardless of the number of conditions treated or services furnished during the patient's stay.

(3) Basis of payment.

(a) Hospital billing. Under the CHAMPUS DRG-based payment system, hospitals are **required** to submit claims (including itemized charges) in accordance with section B. of Chapter 7. The CHAMPUS fiscal intermediary will assign the appropriate DRG to the claim based on the information contained on the claim.

(b) Payment on a per discharge basis. Under the CHAMPUS **DRG-based** payment system, hospitals are paid a predetermined amount per discharge for inpatient **hospital services** furnished to **CHAMPUS** beneficiaries.

(c) Claims priced as of date of admission. Except for interim claims submitted for qualifying **outlier** cases, all claims reimbursed under the CHAMPUS **DRG-based** payment system are **to** be priced as of the date of admission, regardless of when the **claim** is submitted.

(d) Payment in **full**. The **DRG-based** amount paid for inpatient hospital services is the **total** CHAMPUS payment for the inpatient operating costs (as described in subparagraph **A.1.a. (3)(e)**) incurred in furnishing services covered by the CHAMPUS. The full prospective payment amount is payable for each stay during which there is at least one covered day of care, except as provided in subparagraph **A.1.c. (5)(a)1a.**

(e) Inpatient **operating costs**. The CHAMPUS **DRG-based** payment system provides a payment **amount** for **inpatient** operating costs, including:

1 Operating costs for routine services; such as the costs of room, board, and routine nursing services;

2 Operating costs for ancillary services, such as hospital radiology and laboratory services (other than physicians' services) furnished to hospital inpatients;

3 Special care unit operating costs; and

4 Malpractice insurance costs related to services furnished to inpatients.

(f) Discharges and transfers.

1 Discharges. A hospital inpatient is discharged when :

a The patient is formally released from the hospital (release of the **patient** to another hospital as described in subparagraph 2 of this subparagraph, or a leave of absence from the hospital, will not be recognized as a discharge for the purpose **of** determining payment under the CHAMPUS **DRG-based** payment system);

b The patient dies in the hospital; or

c The patient is transferred from the care of a hospital included under the CHAMPUS **DRG-based** payment system to a hospital or unit that is excluded from the prospective payment system.

2 Transfers. Except as provided under subparagraph **A.1.a. (3)(f)1**, a discharge of a hospital inpatient is not counted for purposes of the CHAMPUS **DRG-based** payment system when the patient is transferred:

a From one inpatient area or unit of the hospital to another area or **unit** of the same hospital;

Jul 91

b From the care of a hospital included under the CHAMPUS **DRG-based** payment system to the care of another hospital paid under this system;

c From the care of a hospital included under the CHAMPUS **DRG-based** payment-system to the care of another hospital that is excluded from the CHAMPUS **DRG-based** payment system because of participation in a statewide cost control program which is exempt from the CHAMPUS **DRG-based** payment system under subparagraph **A.1.b.** (1) of this chapter; or

d From the care of a hospital included under the CHAMPUS **DRG-based** payment system to the care of a uniformed services treatment facility.

3 Payment in full to the discharging hospital.
The hospital discharging an inpatient shall be paid **in full under the CHAMPUS DRG-based** payment system.

4 Payment to a hospital transferring an inpatient to another hospital. If a hospital subject to the CHAMPUS **DRG-based** payment system transfers an inpatient to another such hospital, the transferring hospital shall be paid a per diem rate (except that in neonatal cases, other than normal newborns, the hospital will be paid at 125 percent of that per diem rate), as determined under instructions issued by OCHAMPUS, for each day of the patient's stay in that hospital, not to exceed the **DRG-based** payment that would have been paid if the patient had been discharged to another setting. However, if a discharge is classified into DRG No. 456 (Burns, transferred to another acute care facility) or DRG 601 (neonate, transferred less than or equal to 4 days old), the transferring hospital shall be paid in full .

5 Additional payments to transferring hospitals.
A transferring hospital **may** qualify for an additional payment for extraordinary cases that meet the criteria for long-stay or cost **outliers**.

b. Applicability of the DRG system.

(1) Areas affected. The CHAMPUS **DRG-based** payment system shall apply to hospitals' services in the fifty states, the District of Columbia, and Puerto Rico, except that any state which has implemented a separate **DRG-based** payment system or similar payment system in order to control costs and is exempt from the Medicare Prospective Payment System may be exempt from the CHAMPUS **DRG-based** payment system if it requests exemption in writing, and provided payment under such system does not exceed payment which would otherwise be made under the CHAMPUS **DRG-based** payment system.

(2) Services subject to the DRG-based payment system. All normally covered inpatient hospital services furnished to CHAMPUS beneficiaries by hospitals are subject to the CHAMPUS **DRG-based** payment system.

(3) Services exempt from the DRG-based payment system'. The following hospital services, even when provided in a **hospital** subject to the CWUS **DRG-based** payment system, are exempt from the CHAMPUS **DRG-based** payment system. The services in **subparagraphs A.1.b. (3)(a) through (d) and (g) through (i)** shall be reimbursed under the procedures in subsection A.3. of this chapter, and the services in subparagraphs **A.1.b. (3)(e) and (f)** shall be reimbursed under the procedures in section G. of this chapter.

(a) Services provided by hospitals exempt from the **DRG-based** payment system.

(b) All services related to kidney acquisition by Renal Transplantation Centers.

(c) All services related to a heart transplantation which would otherwise be paid under DRG 103.

(d) All services related to liver transplantation when the transplant is performed in a CHAMPUS-authorized **liver** transplantation center.

(e) All professional services provided by hospital-based physicians.

(f) All services provided by nurse anesthetists.

(g) **All** services related to discharges involving pediatric bone marrow transplants (patient under 18 at admission).

(h) **All** services related to discharges involving children who have been determined to be HIV seropositive (patient under 18 at admission) .

(i) All services related to discharges involving pediatric cystic fibrosis (patient under **18** at admission).

(4) Hospitals subject to the CHAMPUS **DRG-based** payment system. All hospitals within the fifty states, the District of Columbia, and Puerto Rico which are certified to provide services to CHAMPUS beneficiaries are subject to the **DRG-based** payment system except for the following hospitals or hospital units which are exempt.

(a) Psychiatric hospitals. A psychiatric hospital which is exempt from the Medicare Prospective Payment System is also exempt from the CHAMPUS **DRG-based** payment system. In order for a psychiatric hospital which does not participate in Medicare to be exempt from the CHAMPUS **DRG-based** payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in Section 412.23 of Title 42 CFR.

Jul 91

(b) Rehabilitation hospitals. A rehabilitation hospital which is exempt from the Medicare Prospective Payment System is also exempt from the CHAMPUS **DRG-based** payment system. In order for a rehabilitation hospital, which does not participate in Medicare to be exempt from the CHAMPUS **DRG-based** payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in Section 412.23 of Title 42 CFR.

(c) Psychiatric and rehabilitation units (distinct parts). A psychiatric or rehabilitation unit which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS **DRG-based** payment system. In order for a distinct unit which does not participate in Medicare to be exempt from the CHAMPUS **DRG-based** payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in Section 412.23 of Title 42 CFR.

(d) Long-term hospitals. A long-term hospital which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS **DRG-based** payment system. In order for a long-term hospital which does not participate in Medicare to be exempt from the CHAMPUS **DRG-based** payment system, it must have an average length of inpatient stay greater than 25 days:

1 As computed by dividing the number of total inpatient days (less leave or pass days) by the total number of discharges for the hospital's most recent fiscal year; or

2 As computed by the same method for the immediately preceding six-month period, if a change in the hospital's average length of stay is indicated.

(e) Sole community hospitals. Any hospital which has qualified for special treatment **under** the Medicare prospective payment system as a sole community hospital and has not given up that classification is exempt from the CHAMPUS **DRG-based** payment system. (See Subpart G of 42 CFR Part 412.)

(f) Christian Science sanitoriums. All Christian Science sanitoriums (as defined in paragraph B.4.h. of Chapter 6) are exempt from the CHAMPUS **DRG-based** payment system.

(g) Cancer hospitals. Any hospital which **qualifies** as a cancer hospital under the Medicare **standards** and has elected to be exempt from the Medicare prospective payment system is exempt from the CHAMPUS **DRG-based** payment system. (See 42 CFR Section 412.94.)

(h) Hospitals outside the 50 states, the District of Columbia, and Puerto Rico. A hospital is excluded from the CHAMPUS **DRG-based** Payment system if it is not located in one of the fifty States, the District of Columbia, or Puerto Rico.

(5) Hospitals which do not participate in Medicare. It is not required that a hospital be a Medicare-participating provider in order to be an authorized CHAMPUS provider. However, any hospital which is subject to the CHAMPUS **DRG-based** payment system **and which** otherwise meets CHAMPUS requirements but which is not a Medicare-participating provider (having completed a form **HCFA-1514**, Hospital Request for Certification in the Medicare/Medicaid Program and a form **HCFA-1561**, Health Insurance Benefit Agreement) must complete a participation agreement with **OCHAMPUS**. By completing the participation agreement, the hospital agrees to participate on all CHAMPUS inpatient claims and to accept the CHAMPUS-determined allowable amount as payment in full for these claims. Any hospital which does not participate in Medicare and does not complete a participation agreement with OCHAMPUS will not be authorized to provide services to CHAMPUS beneficiaries.

c. Determination of payment amounts. The actual payment for an individual claim under the **CHAMPUS DRG-based payment** system is calculated by multiplying the appropriate adjusted standardized amount (adjusted to account for area wage differences using the wage indexes used in the Medicare program) by a weighting factor specific to each DRG.

(1) Calculation of DRG Weights.

(a) Grouping of charges. All discharge records in the database shall be grouped by DRG.

(b) Remove DRGs 469 and 470. Records from DRGs 469 and 470 **shall** be removed from the database.

(c) Indirect medical education standardization. To standardize the charges for the cost effects of indirect medical education factors, each teaching hospital's charges will be divided by 1.0 plus the following ratio on a hospital-specific basis:

$$1.43 \times 1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \cdot .5795 - 1.0$$

(d) Wage level standardization. To standardize the charge records for area wage differences, each **charge** record **will** be divided into labor-related and nonlabor-related portions, and the labor-related portion shall be divided by the most recently available Medicare wage index for the area. The labor-related and **nonlabor-related** portions will then be added together.

(e) Elimination of statistical outliers. All unusually high or low charges shall be removed from the database.

Jul 91

(f) Calculation of DRG average charge. After the standardization for indirect medical **education**, and area wage differences, an average charge for each DRG shall be computed **by** summing charges in a DRG and dividing that sum **by** the number **of records** in the DRG.

(g) Calculation of national average charge per discharge. A national average charge per discharge shall be calculated by summing all charges and dividing that sum by the **total** number of records from all DRG categories.

(h) DRG relative weights. DRG relative weights shall be calculated for each DRG category **by dividing** each DRG average charge by the national average charge.

(2) Empty and low-volume DRGs. The Medicare weight shall be used for any DRG with less than ten (10) occurrences in the CHAMPUS database. The short-stay thresholds shall be set at one day for these DRGs and the long-stay thresholds **shall** be set at the FY 87 Medicare thresholds.

(3) Updating DRG weights. The CHAMPUS DRG weights shall be updated or adjusted as follows:

(a) DRG weights shall be recalculated annually using CHAMPUS charge data and the methodology described in subparagraph A.1.c. (1) of this chapter.

(b) When a new DRG is created, CHAMPUS **will**, if practical, calculate a weight for it using an appropriate charge sample (if available) and the methodology described in subparagraph A.1.c. (1) of this chapter.

(c) In the case of any other change under Medicare to an existing DRG weight (such as in connection with technology changes), CHAMPUS shall adjust its weight for that DRG in a manner comparable to the change made by Medicare.

(4) Calculation of the adjusted standardized amounts. The following procedures **shall** be followed in calculating the CHAMPUS adjusted standardized amounts.

(a) Differentiate large urban, other urban, and-rural charges. All charges in the database shall be sorted into large urban, other urban, and rural groups (using the same definitions for these categories used in the Medicare program). The following procedures will be applied to each group.

(b) Indirect medical education standardization. To standardize the charges for the cost effects of indirect medical education

factors, each teaching hospital's charges will be divided by 1.0 plus the following ratio on a hospital-specific basis:

$$1.43 \times \left(1.0 + \frac{\text{number of interns} + \text{residents}}{\text{number of beds}} \right)^{.5795} - 1.0$$

(c) Wage level standardization. To standardize the charge records for area wage differences, each charge record will be divided into labor-related and nonlabor-related portions, and the labor-related portion shall be divided by the most recently available Medicare wage index for the area. The labor-related and nonlabor-related portions will then be added together.

(d) Apply the cost to charge ratio. Each charge is to be reduced to a representative cost by using the Medicare cost to charge ratio. This amount shall be increased by 1 percentage point in order to reimburse hospitals for bad debt expenses attributable to CHAMPUS beneficiaries.

(e) Preliminary base year standardized amount. A preliminary base year standardized amount shall be calculated by summing all costs in the database applicable to the large urban, other urban, or rural group and dividing by the total number of discharges in the respective group.

(f) Update for inflation. The preliminary base year standardized amounts shall be updated using an annual update factor equal to 1.07 to produce fiscal year 1988 preliminary standardized amounts. Thereafter, any development of a new standardized amount will use an inflation factor equal to the hospital market basket index used by the Health Care Financing Administration in their Prospective Payment System.

(g) The preliminary standardized amounts, updated for inflation, shall be divided by a system standardization factor so that total DRG outlays, given the database distribution across hospitals and diagnoses, are equal to the total charges reduced to costs.

(h) Labor and nonlabor portions of the adjusted standardized amounts. The adjusted standardized amounts shall be divided into labor and nonlabor portions in accordance with the Medicare division of labor and nonlabor portions.

(5) Adjustments to the DRG-based payment amounts. The following adjustments to the DRG-based amounts (the weight multiplied by the adjusted standardized amount) will be made.

(a) Outliers. The DRG-based payment to a hospital shall be adjusted for atypical cases. These outliers are those cases that have either an unusually short length-of-stay or extremely long length-of-stay or

Jul 91

that involve extraordinarily high costs when compared to most discharges classified in the same DRG. Cases which qualify as both a length-of-stay **outlier** and a cost **outlier** shall be paid at the rate which results in the greater payment.

1 Length-of-stay outliers. Length-of-stay **outliers** shall be identified and paid by the **fiscal** intermediary when the claims are processed.

a Short-stay outliers. Any discharge with a length-of-stay (LOS) less than 1.94 standard deviations from the DRG's geometric LOS shall be classified as a short-stay **outlier**. Short-stay **outliers** shall be reimbursed at 200 percent of the per diem rate for the DRG for each covered day of the hospital stay, not to exceed the DRG amount. The per diem rate shall **equal** the DRG amount divided by the geometric mean length-of-stay for the DRG.

b Long-stay outliers. Any discharge which has a length-of-stay (LOS) **exceeding** the lesser of 3.00 standard deviations or 24 days (1.94 standard deviations or 17 days for neonate services and for services in children's hospitals) from the DRG's geometric mean LOS shall be classified as a long-stay **outlier**. Long-stay **outliers** shall be reimbursed the **DRG-based** amount plus 60 percent (90 percent for DRGs related to burn cases) of the per diem rate for the DRG for each covered day of care beyond the long-stay **outlier** cutoff. The per diem rate shall equal the **DRG** amount divided by the geometric mean LOS for the DRG.

2 Cost outliers. Any discharge which has "standardized costs that exceed a threshold of the greater of two times the **DRG-based** amount or \$28,000 (\$13,500 for neonate services and for services in children's hospitals) shall qualify as a cost **outlier**. The standardized costs shall be calculated by multiplying the total charges by the factor described in subparagraph A.1.c. (4)(d) and adjusting this amount for indirect medical education costs. Cost **outliers** shall be reimbursed the **DRG-based** amount plus 75 percent (90 percent for DRGs related to burn cases and 80 percent for neonatal services and for services in children's hospitals) of all costs exceeding the threshold. Additional payment for cost **outliers** shall be made only upon request by the hospital. Notwithstanding the threshold amount stated in the first sentence of this subparagraph and the marginal payment percentage stated in the third sentence of this subparagraph, for all discharges to patients admitted prior to November 21, 1988, a threshold amount of \$13,500 (rather than \$28,000) shall apply and (except for burn cases, neonatal services and services in children's hospitals) a marginal payment percentage of 60 percent (rather than 75 percent) shall apply.

(b) Wage Adjustment. CHAMPUS will adjust the labor portion of the standardized amounts according to the hospital's area wage index.

(c) Indirect Medical Education Adjustment. The wage adjusted DRG payment will also be multiplied by 1.0 plus the hospital's indirect medical education ratio.

(d) Children's Hospital Differential. With respect to claims from children's hospitals, the appropriate adjusted standardized amount shall also be adjusted by a children's hospital differential.

1 Qualifying children's hospitals. Hospitals qualifying for the children's hospital differential are hospitals that are exempt from the Medicare Prospective Payment System, or, in the case of hospitals that do not participate in Medicare, that meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in 42 CFR 412.23.

2 Calculation of differential. The differential shall be equal to the **difference** between a specially calculated children's hospital adjusted standardized amount and the adjusted standardized amount for fiscal year 1988. The specially calculated children's hospital adjusted standardized amount shall be calculated in the same manner as set forth in subparagraph **A.1.c.** (4), except that:

a The base **period** shall be fiscal year 1988 and shall represent total **estimated** charges for discharges that occurred during fiscal year 1988.

b No cost to charge ratio shall be applied.

c Capital costs and direct medical education costs will be included in the calculation.

d The factor used to update the database for inflation to produce the fiscal year 1988 base **period** amount shall be the applicable Medicare inpatient hospital market basket rate.

3 Transition rule. Until March 1, 1992, separate differentials shall be used **for** each higher volume children's hospital (individually) and for **all** other children's hospitals (in the aggregate). For this purpose, a higher volume hospital is a hospital that had 50 or more CHAMPUS discharges in fiscal year 1988.

4 Hold harmless provision. At such time as the weights initially assigned to neonatal DRGs are recalibrated based on sufficient volume of CHAMPUS claims records, children's hospital differentials shall be recalculated and appropriate retrospective and prospective adjustments shall be made. To the extent practicable, the recalculation shall also include reestimated values of other factors (including but not limited to direct education and capital costs and indirect education factors) for which more accurate data became available.

5 No update for inflation. The children's hospital differential, calculated (and later recalculated under the hold harmless provision) for the base period of fiscal year 1988, shall not be updated for subsequent fiscal years.

Jul 91

6 Administrative corrections. In connection with determinations pursuant to subparagraph A.1.c.(5)(d)3 of this chapter, any children's hospital that believes OCHAMPUS erroneously failed to classify the hospital as a high volume hospital or incorrectly calculated (in the case of a high volume hospital) the hospital's differential may obtain administrative corrections by submitting appropriate documentation to the Director, OCHAMPUS (or designee).

(6) Updating the adjusted standardized amounts. Beginning in FY 1989, the adjusted standardized amounts will be updated by the Medicare annual update factor, unless the adjusted standardized amounts are recalculated.

(7) Annual Cost Pass-Throughs.

(a) Capital costs. When requested in writing by a hospital, CHAMPUS shall reimburse the hospital its share of actual capital costs as reported annually to the CHAMPUS fiscal intermediary. Payment for capital costs shall be made annually based on the ratio of CHAMPUS inpatient days for those beneficiaries subject to the CHAMPUS DRG-based payment system to total inpatient days applied to the hospital's total allowable capital costs. Reductions in payments for capital costs which are required under Medicare shall also be applied to payments for capital costs under CHAMPUS.

1 Costs included as capital costs. Allowable capital costs are those specified in Medicare Regulation Section 413.130, as modified by Section 412.72.

2 Services, facilities, or supplies provided by supplying organizations. If services, facilities, or supplies are provided to the hospital by a supplying organization related to the hospital within the meaning of Medicare Regulation Section 413.17, then the hospital must include in its capital-related costs, the capital-related costs of the supplying organization. However, if the supplying organization is not related to the provider within the meaning of 413.17, no part of the charge to the provider may be considered a capital-related cost unless the services, facilities, or supplies are capital-related in nature and:

a The capital-related equipment is leased or rented by the provider;

b The capital-related equipment is located on the provider's premises; and

c The capital-related portion of the charge is separately specified in the charge to the provider.

(b) Direct medical education costs. When requested in writing by a hospital, CHAMPUS shall reimburse the hospital its actual direct medical education costs as reported annually to the CHAMPUS fiscal intermediary. Such teaching costs must be for a teaching program approved

under Medicare Regulation Section 413.85. Payment for direct medical education costs shall be made annually based on the ratio of CHAMPUS inpatient days for those beneficiaries subject to the CHAMPUS **DRG-based** payment system to total inpatient **days** applied to the hospital's total allowable direct medical education costs. Allowable direct medical education costs are those specified in Medicare Regulation Section 413.85.

(c) Information necessary for payment of capital and direct medical education costs. All hospitals subject to the CHAMPUS **DRG-based** payment system, except for children's hospitals, may be reimbursed for allowed capital and direct medical education costs by submitting a request to the CHAMPUS contractor. Such request shall cover the one-year period corresponding to the hospital's Medicare cost-reporting period. The first such request may cover a period of less than a full year--from the effective date of the CHAMPUS **DRG-based** payment system to the end of the hospital's Medicare cost-reporting period. All costs reported to the CHAMPUS contractor must correspond to the costs reported on the hospital's Medicare cost report. In the case of children's hospitals that request reimbursement under this clause for capital and/or direct medical education costs, the hospital must submit appropriate base period cost information, as determined by the Director, **OCHAMPUS** (or designee). (If these costs change as a result of a subsequent audit by Medicare, the revised costs are to be reported to the hospital's CHAMPUS contractor within 30 days of the date the hospital is notified of the change.) The request must be signed by the hospital official responsible for verifying the amounts and shall contain the following information.

1 The hospital's name.

2 The hospital's address.

3 The hospital's CHAMPUS provider number.

4 The hospital's Medicare provider number.

5 The period covered--this must correspond to the hospital's Medicare cost-reporting period.

6 Total inpatient days provided to all patients in units subject to DRG-based payment.

7 Total allowed CHAMPUS inpatient days provided in units subject to **DRG-based** payment.

8 Total allowable capital costs.

9 Total allowable direct medical education costs.

10 Total full-time equivalents for:

a Residents.

b Interns

Jul 91

11 Total inpatient beds as of the end of ~~the~~ cost-reporting period. **If** this has changed during the reporting period, an explanation of the change must be provided.

12 Title of official signing the report.

13 Reporting date.

14 The report shall contain a certification statement. that any changes to the items in subparagraphs 6, 7, 8, 9, or 10, which are a result of an audit of the hospital's Medicare cost-report, shall be reported to **CHAMPUS** within thirty (30) days of the date the hospital is notified of the change.

2. **CHAMPUS** mental health per diem payment system. The CHAMPUS mental health per diem payment system shall ~~be~~ used to reimburse for inpatient mental health hospital care in specialty psychiatric hospitals and units. Payment is made on the basis of prospectively determined rates and paid on a per diem basis. The system uses two sets of per diems. One set of per diems applies to hospitals and units that have a relatively higher number of CHAMPUS discharges. For these hospitals and units, the system uses hospital-specific per diem rates. The other set of per diems applies to hospitals and units with a relatively lower number of CHAMPUS discharges. For these hospitals and units, the system uses regional per diems, and further provides for adjustments for area wage differences and indirect medical education costs and additional pass-through payments for direct medical education costs.

a. Applicability of the **mental health** per diem payment system.

(1) **Hospitals** and units covered. The CHAMPUS mental health per diem payment system applies to services covered (see subparagraph **A.2.a.** (2) below) that are provided in Medicare prospective payment system (**PPS**) exempt psychiatric specialty hospitals and all Medicare PPS exempt psychiatric specialty units of other hospitals. In addition, any psychiatric hospital that does not participate in Medicare, or any other hospital that has a psychiatric specialty unit that has not been so designated for exemption from the Medicare prospective payment system because the hospital does not participate **in** Medicare, may be designated as a psychiatric hospital or psychiatric specialty unit for purposes of the CHAMPUS mental health per diem payment system upon demonstrating that it meets the same criteria (as determined by the Director, **OCHAMPUS**) as required for the Medicare exemption. The CHAMPUS mental health per diem payment system does not apply to mental health services provided in other hospitals.

(2) Services covered-. Unless specifically exempted, all covered hospitals' and units' inpatient claims which are classified into a mental health DRG (DRG categories 425-432, but not DRG 424) or an alcohol/drug abuse DRG (DRG categories 433-437) shall be subject to the mental health per diem payment system.

b. Hospital-specific per diems for higher volume hospitals and units. This paragraph describes the per diem payment amounts for hospitals and units with a higher volume of CHAMPUS discharges.

(1) Per diem amount. A hospital-specific per diem amount shall be calculated for each hospital and unit with a higher volume of CHAMPUS discharges. The base period per diem amount shall be equal to the hospital's average daily charge in the base period. The base period amount, however, may not exceed the cap described in subparagraph A.2.b. (2), below. The base period amount shall be updated in accord with paragraph A.2.d. of this chapter.

(2) Cap. The base period per diem amount may not exceed the eightieth **percentile** of the average daily charge weighted for **all** discharges throughout the United States from all higher volume hospitals.

(3) Review of per diem amount. Any hospital or unit. which believes **OCHAMPUS** calculated a **hospital-specific** per diem which differs by more than \$5.00 from that calculated by the hospital or unit may apply to the Director, **OCHAMPUS**, or a designee, for a recalculation. The burden of proof shall be on the hospital.

c. Regional per diems for lower volume hospitals and units. This paragraph **describes** the per diem amounts for hospitals and units with a lower volume of CHAMPUS discharges.

(1) Per diem amounts. Hospitals and units with a lower volume of CHAMPUS patients shall be paid on the basis of a regional per diem amount, adjusted **for** area wages and indirect medical education. Base period regional per diems shall be calculated based upon all CHAMPUS lower volume hospitals' claims paid during the base period. Each regional per diem amount shall be the quotient of all covered charges divided by all covered days of care, reported on all CHAMPUS claims from lower volume hospitals in the region paid during the base period, after having standardized for indirect medical education costs and area wage indexes and subtracted direct medical education costs. Regional per diem amounts are adjusted in accordance with subparagraph A.2.c. (3), below. Additional pass-through payments to lower volume hospitals are made in accordance with subparagraph A.2.c. (4), below. The regions shall be the same as the federal census regions.

(2) Review of per diem amount. Any hospital that believes the regional per diem amount applicable to that hospital has been erroneously calculated by **OCHAMPUS** by more than \$5.00 may submit to the Director, **OCHAMPUS**, or a designee, evidence supporting a different regional per diem. The burden of proof shall be on the hospital.

(3) Adjustments to regional per diems. Two adjustments **shall** be made to the regional per diem rates.

(a) Area wage index. The same area wage indexes used for the CHAMPUS DRG-based payment system (see subparagraph A.1.c. (5)(b) of this chapter) shall be applied to the wage portion of the applicable regional per diem rate for each day of the admission. The wage portion shall be the same as that used for the **CHAMPUS** DRG-based payment system.

(b) Indirect medical education. The indirect medical education adjustment factors shall be calculated for teaching hospitals in the same manner as is used in the CHAMPUS **DRG-based** payment system (see subparagraph **A.1.c. (5)(c)** of this chapter) and applied to the applicable regional per diem rate for each day of the admission.

(4) Annual cost pass-through for direct medical education. In addition to payments made to lower volume hospitals under paragraph **A.2.c.**, CHAMPUS shall annually reimburse hospitals for actual direct medical education costs associated with services to CHAMPUS beneficiaries. This reimbursement shall be done pursuant to the same procedures as are applicable to the CHAMPUS DRG-based payment system (see subparagraph **A.1.c. (7)** of this chapter) .

d. Base period and update factors.

(1) Base period. The base period for calculating the hospital-specific and **regional per diems**, as described in paragraphs A.2.b. and c. above, is federal fiscal year 1988. Base period calculations shall be based on actual claims paid during the period July 1, 1987 through May 31, 1988, trended forward to represent the 12-month period ending September 30, 1988 on the basis of the Medicare inpatient hospital market basket rate.

(2) Alternative hospital-specific data base. Upon application of a higher volume hospital or unit to the Director, **OCHAMPUS**, or a designee, the hospital or unit may have its hospital-specific base period calculations based on claims with a date of discharge (rather than date of payment) between July 1, 1987 through May 31, 1988 if it has generally experienced unusual delays in claims payments and if the use of such an alternative data base would result in a difference in the per diem amount of at least \$5.00. For this purpose, the unusual delays means that the hospital's or unit's average time period between date of discharge and date of payment is more than two standard deviations **longer** than the national average.

(3) Update factors. The hospital-specific per diems and the regional per diems calculated for the base period pursuant to paragraphs **A.2.b.** and c. of this chapter shall be in effect for federal fiscal year 1989; there will be no additional update for fiscal year 1989. For subsequent federal fiscal years, each per diem shall be updated by the Medicare update factor for hospitals and units exempt from the Medicare prospective payment system. Hospitals and units with hospital-specific rates will be notified of their respective rates prior to the beginning of each federal fiscal year. New hospitals shall be notified at such time as the hospital rate is determined. The actual amounts of each regional per diem that will apply in any federal fiscal year shall be published in the Federal Register prior to the start of that fiscal year.

e. Higher volume hospitals. This paragraph describes the classification of and other provisions pertinent to hospitals with a higher volume of CHAMPUS patients.

(1) In general. Any hospital or unit that had an annual rate of 25 or more CHAMPUS **discharges** of CHAMPUS patients during the period July 1, 1987 through May 31, 1988 **shall be** considered a higher volume hospital during federal fiscal year 1989 and **a11** subsequent fiscal years. All other hospitals and units covered by the CHAMPUS mental health per diem payment system shall be considered lower volume hospitals.

(2) Hospitals that subsequently become higher volume hospitals. In any federal fiscal year in which a hospital, including a new hospital (see subparagraph **A.2.e.** (3) below), not. previously classified as a higher volume hospital has 25 or more CHAMPUS discharges, that hospital shall be considered to be a higher volume hospital during the next federal fiscal year and all subsequent fiscal years. The hospital specific per diem amount shall be calculated in accordance with the provisions of paragraph **A.2.b.** of this chapter, except that the base period average daily **charge** shall be deemed to be the hospital's average **daily** charge in the year in which the hospital had 25 or more discharges, adjusted by the percentage change in average daily charges for all higher volume hospitals and units between the year in which the hospital had 25 or more CHAMPUS discharges and the base period. The base period amount, however, may not exceed the cap described in subparagraph **A.2.b.** (2) of this chapter.

(3) Special retrospective payment provision for new hospitals. For purposes of this subparagraph, a new hospital is a hospital that qualifies for the Medicare exemption from the rate of increase ceiling applicable to new hospitals which are PPS-exempt psychiatric hospitals. Any new hospital that **becomes** a higher volume hospital, in addition to qualifying prospectively as a higher volume hospital for purposes of subparagraph **A.2.e.** (2) above, may additionally, upon application to the Director, **OCHAMPUS**, receive a retrospective adjustment. The retrospective adjustment shall be calculated so that the hospital receives the same government share payments it would have received had it been designated *a* higher volume hospital for the federal fiscal year in which it first had 25 or more CHAMPUS discharges and the preceding fiscal year (if it had any CHAMPUS patients during the preceding fiscal year). Such new hospitals must agree not to bill CHAMPUS beneficiaries for any additional costs beyond that determined initially.

(4) Review of classification. Any hospital or unit which OCHAMPUS erroneously fails to classify **as a** higher volume hospital may apply to the Director, **OCHAMPUS**, or a designee, for such a classification. The hospital shall have the burden of proof.

f. Payment for hospital based professional services. Lower volume hospitals and units may not bill separately for hospital based professional mental health services; payment for those services is included in the per diems. Higher volume hospitals and units, whether they billed CHAMPUS separately for hospital based professional mental health services or included those services in the hospital's billing to CHAMPUS, shall continue the practice in effect during the period July 1, 1987 to May 31, 1988 (or other data base period used for calculating the hospital's or unit's per diem), except that any such hospital or unit may change its prior practice (and obtain an appropriate revision in its per diem) by providing to **OCHAMPUS**

notice in accordance with procedures established by the Director, OCHAMPUS, or a designee.

g. Leave days. **CHAMPUS** shall not pay for days where the patient is absent on leave from the specialty psychiatric hospital or unit. The hospital must identify these days when claiming reimbursement. CHAMPUS shall not count a patient's leave of absence as a discharge in determining whether a facility should be classified as a higher volume hospital pursuant to paragraph A.2.e. of this chapter.

h. Exemptions from the CHAMPUS mental health per diem payment system. The following providers and **procedures** are exempt from the CHAMPUS mental health per diem payment system.

(1) Non-specialty providers. Providers of inpatient care which are not either psychiatric hospitals or psychiatric specialty units as described in subparagraph A.2.a. (1) of this chapter are exempt from the CHAMPUS mental health per diem payment system. Such providers should refer to subsection A1. of this chapter for provisions pertinent to the CHAMPUS DRG-based payment system.

(2) DRG 424. Admissions for operating room procedures involving a principal diagnosis of mental illness (services which group into DRG 424) are exempt from the per diem payment system. They will be reimbursed pursuant to the provisions of subsection A.3. of this chapter.

(3) Non-mental health services. Admissions for non-mental health procedures in specialty psychiatric hospitals and units are exempt from the per diem payment system. They will be reimbursed pursuant to the provisions of subsection A.3. of this chapter.

(4) Sole community hospitals. Any hospital which has qualified for special treatment under the Medicare prospective payment system as a sole community hospital and has not given up that classification is exempt.

(5) Hospitals outside the U.S. A hospital is exempt if it is not located in one of the 50 states, the District of Columbia or Puerto Rico.

3. Billed charges and set rates. The allowable costs for authorized care in all **hospitals** not subject to the CHAMPUS **DRG-based** payment system or the CHAMPUS mental health per diem payment system shall be determined on the basis of billed charges or set rates. Under this procedure the allowable costs may not exceed the lower of:

a. The actual charge for such service made to the general public;
or

b. The allowed charge applicable to the policyholders or subscribers of the CHAMPUS fiscal intermediary for comparable services under comparable circumstances, when extended to CHAMPUS beneficiaries by consent or agreement; or

c. The allowed charge applicable to the citizens of the community

or state as established by local or state regulatory authority, excluding title XIX of the Social Security Act or other welfare program, when extended to CHAMPUS beneficiaries by consent or agreement.

4. CHAMPUS discount rates. The CHAMPUS-determined allowable cost for authorized care in any hospital may be based on discount rates established under section I. of this chapter.

B. SKILLED NURSING FACILITIES (SNFs)

The CHAMPUS-determined allowable cost for reimbursement of a SNF shall be determined on the same basis as for hospitals which are **not** subject to the CHAMPUS **DRG-based** payment system.

C. REIMBURSEMENT FOR OTHER THAN HOSPITALS AND SNFS

The Director, **OCHAMPUS**, or a designee, shall establish such other methods of determining allowable cost or charge reimbursement for those institutions, other than hospitals and SNFS, as may be required.

D. REIMBURSEMENT OF FREESTANDING AMBULATORY SURGICAL CENTERS

Authorized care furnished by freestanding ambulatory surgical centers shall be reimbursed on the basis of the CHAMPUS-determined reasonable cost.

E. REIMBURSEMENT OF BIRTHING" CENTERS

1. Reimbursement for maternity care and childbirth services furnished by an authorized birthing center shall be limited to the lower of the CHAMPUS established all-inclusive rate or the center's most-favored all-inclusive rate.

2. The all-inclusive rate shall include the following to the extent that they are usually associated with a normal pregnancy and childbirth: laboratory studies, prenatal management, **labor** management, delivery, **post-partum** management, newborn care, birth assistant, certified nurse-midwife professional services, physician professional services, and the use of the facility.

3. The CHAMPUS established all-inclusive rate is equal to the sum of the CHAMPUS area prevailing professional charge for total obstetrical care for a normal pregnancy and delivery and the sum of the average CHAMPUS allowable institutional charges for supplies, laboratory, and delivery room for a hospital inpatient normal delivery. The CHAMPUS established all-inclusive rate areas will coincide with those established for prevailing professional charges and **will** be updated concurrently with the CHAMPUS area prevailing professional charge database.

4. Extraordinary maternity care services, when otherwise authorized, may be reimbursed at the lesser of the **billed** charge or the CHAMPUS allowable charge .

Jul 91

5. Reimbursement for an incomplete course of care will be limited to claims for professional services and tests where the beneficiary has been screened but rejected for admission into the birthing center program, or where the woman has been admitted but is discharged from the birthing center program prior to delivery, adjudicated as individual professional services and items.

6. The beneficiary's share of the total reimbursement to a birthing center is limited to the cost-share amount plus the amount billed for non-covered services and supplies.

F. REIMBURSEMENT OF RESIDENTIAL TREATMENT CENTERS

The CHAMPUS rate is the per diem rate that CHAMPUS will authorize for all mental health services rendered to a patient and the patient's family as part of the total treatment plan submitted by a CHAMPUS-approved RTC, and approved by the Director, OCHAMPUS, or designee.

1. The all-inclusive per diem rate for RTCS operating or participating in CHAMPUS during the base period of July 1, 1987, through June 30, 1988, will be the lowest of the following conditions:

a. The CHAMPUS rate paid to the RTC for all-inclusive services as of June 30, 1988, adjusted by the Consumer Price Index - Urban (CPI-U) for medical care as determined applicable by the Director, OCHAMPUS, or designee; or

b. The per diem rate accepted by the RTC from any other agency or organization (public or private) that is high enough to cover one-third of the total patient days during the 12-month period ending June 30, 1988, adjusted by the CPI-U; or

NOTE : The per diem rate accepted by the RTC from any other agency or organization includes the rates accepted from entities such as Government contractors in CHAMPUS demonstration projects.

c. An OCHAMPUS determined capped per diem amount not to exceed the 80th percentile of all established CHAMPUS RTC rates nationally, weighted by total CHAMPUS days provided at each rate during the base period discussed in F.1. above.

2. The all-inclusive per diem rates for RTCS which began operation after June 30, 1988, or began operation before July 1, 1988, but had less than 6 months of operation by June 30, 1988, will be calculated based on the lower of the per diem rate accepted by the RTC that is high enough to cover one-third of the total patient days during its first 6 to 12 consecutive months of operation, or the OCHAMPUS determined capped amount. Rates for RTCS beginning operation prior to July 1, 1988, will be adjusted by an appropriate CPI-U inflation factor for the period ending June 30, 1988- A period of less than 12 months will be used only when the RTC has been in operation for less than 12 months. Once a full 12 months is available, the rate will be recalculated.

3. The first three days of each approved therapeutic absence will be allowed at 100 percent of the CHAMPUS determined all-inclusive per diem rate. Beginning with day four, reimbursement will be at 75 percent of that rate.

4. All educational costs, whether they include routine education or special education costs, are excluded from reimbursement except when appropriate education is not available from, or not payable by, a cognizant public entity.

a. The RTC shall exclude educational costs from its daily costs.

b. The RTC's accounting system must be adequate to assure CHAMPUS is not billed for educational costs.

c. The RTC may request payment of educational costs on an individual case basis from the Director, OCHAMPUS, or designee, when appropriate education is not available from, or not payable by, a cognizant public entity. To qualify for reimbursement of educational costs in individual cases, the RTC shall comply with the application procedures established by the Director, OCHAMPUS, or designee, including, but not limited to, the following:

(1) As part of its admission procedures, the RTC must counsel and assist the beneficiary and the beneficiary's family in the necessary procedures for assuring their rights to a free and appropriate public education.

(2) The RTC must document any reasons why an individual beneficiary cannot attend public educational facilities and, in such a case, why alternative educational arrangements have not been provided by the cognizant public entity.

(3) If reimbursement of educational costs is approved for an individual beneficiary by the Director, OCHAMPUS, or designee, such educational costs shall be shown separately from the RTC's daily costs on the CHAMPUS claim. The amount paid shall not exceed the RTC's most-favorable rate to any other patient, agency, or organization for special or general educational services whichever is appropriate.

(4) If the RTC fails to request CHAMPUS approval of the educational costs on an individual case, the RTC agrees not to bill the beneficiary or the beneficiary's family for any amounts disallowed by CHAMPUS. Requests for payment of educational costs must be referred to the Director, OCHAMPUS, or designee for review and a determination of the applicability of CHAMPUS benefits.

5. Any future adjustments to the RTC rates will be limited to annual changes in the CPI-U for medical care. at the discretion of the Director, OCHAMPUS or designee.

Jul 91

G. REIMBURSEMENT OF INDIVIDUAL HEALTH-CARE PROFESSIONALS AND OTHER NON-INSTITUTIONAL HEALTH-CARE PROVIDERS

The CHAMPUS-determined reasonable charge (the amount allowed **by** CHAMPUS) for the service of an individual health-care professional or other non-institutional health-care provider (even **if** employed by or under contract to an institutional provider) shall be determined by one of the following methodologies, that **is**, whichever is in effect in the specific geographic location at the time covered services and supplies are provided to a CHAMPUS beneficiary.

1. Allowable charge method. The allowable charge method is the preferred and primary method for reimbursement of individual health-care professionals and other non-institutional health-care providers.

a. The allowable charge for authorized care shall be the lowest of the amounts identified in subparagraphs (1), (2), and (3) below.

(1) The billed charge for the service.

(2) The prevailing charge level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services in the same locality during the base period.

NOTE : Prevailing charges shall continue **to** be calculated in accordance with any limitations set forth in the DoD Appropriation Acts, as implemented in instructions issued by the Director, OCHAMPUS.

(a) The 80th percentile of charges shall **be** determined on the basis of statistical data and methodology acceptable to the Director, OCHAMPUS, or a designee.

(b) The **base period** shall be a period of 12 calendar months and shall be **adjusted** at least once a year, unless the Director, OCHAMPUS, determines that a **different** period for **adjustment is** appropriate and publishes a notice to that effect in the Federal Register. Prior to publishing the final notice, a notice of intent shall have been published, which allowed a 30-day period for public comment on the proposed action.

(3) For charges from physicians and other individual professional providers, the fiscal year 1988 prevailing charges adjusted by the Medicare Economic Index (MEI), as the MEI is applied to Medicare prevailing charge levels.

(a) In any year in which the Medicare program applies a different **MEI** to primary care services, CHAMPUS will include maternity care and delivery services and well baby care services as primary care for the purposes of applying the MEI.

(b) The Director, OCHAMPUS, shall issue procedural instructions to apply the MEI under CHAMPUS.

b. A charge that exceeds the prevailing charge can be determined to be allowable only when unusual circumstances or medical complications justify the higher charge. The allowable charge may not exceed the billed charge under any circumstances.

c. The allowable charge for physician assistant services other than assistant-at-surgery may not exceed 85 percent of the allowable charge for a comparable service rendered by a physician performing the service in a similar location. For cases in which the physician assistant and the physician perform component services of a procedure other than assistant-at-surgery (e.g., home, office or hospital visit), the combined allowable charge for the procedure may not exceed the allowable charge for the procedure rendered by a physician alone. The allowable charge for physician assistant services performed as an **assistant-at-surgery** may not exceed 65 percent of the allowable charge for a physician **serving** as an assistant surgeon when authorized as CHAMPUS benefits in accordance with the provisions of Chapter 4 C.3.C. of this Part. Physician assistant services must be billed through the employing physician who must be an authorized CHAMPUS provider.

2. All-inclusive rate. Claims from individual health-care professional **providers for services** rendered to CHAMPUS beneficiaries residing in an RTC that is either being reimbursed on an all-inclusive per diem rate, or is billing an all-inclusive per diem rate, shall be denied; with the exception of independent health-care professionals providing geographically distant family therapy to a family member residing a minimum of 250 miles from the RTC or covered medical services related to a **nonmental** health condition rendered outside the RTC. Reimbursement for individual professional services is included in the rate paid the institutional provider.

3. Alternative method. The Director, OCHAMPUS, or a designee, may, subject to the approval of the **ASD(HA)**, establish an alternative method of reimbursement designed to produce reasonable control over health care costs and to ensure a high level of acceptance of the **CHAMPUS-determined** charge by the individual health-care professionals or other noninstitutional health-care providers furnishing services and supplies to CHAMPUS beneficiaries. Alternative methods may not result in reimbursement greater than the allowable charge method above.

H. REIMBURSEMENT UNDER THE MILITARY-CIVILIAN HEALTH SERVICES PARTNERSHIP PROGRAM

The Military-Civilian Health Services Partnership Program, as authorized by Section 1096, Chapter 55, Title 10, provides for the sharing of staff, equipment, and resources between the civilian and military health care system in order to achieve more effective, efficient, or economical health care for authorized beneficiaries. Military treatment facility commanders, based upon the authority provided by their respective Surgeons General of the military departments, are responsible for entering into individual partnership agreements only when they have determined specifically that use of the Partnership program is more economical overall to the Government than referring the need for health care services to the civilian community under the normal operation of the CHAMPUS Program. (See Section P. of Chapter 1, for general requirements of the Partnership Program.)

1. Reimbursement of institutional health care providers. Reimbursement of institutional health care providers **under** the Partnership Program shall be on the same basis as non-Partnership providers.

2. Reimbursement of individual health-care professionals and other non-institutional health care providers. Reimbursement of individual health care professional and other non-institutional health care providers shall be on the same basis as non-Partnership providers as detailed in Section G. of this chapter.

I. ACCOMMODATION OF DISCOUNTS UNDER PROVIDER REIMBURSEMENT METHODS

1. General rule. The Director, OCHAMPUS (or designee) has authority to reimburse a provider at an amount below the amount usually paid pursuant to this chapter when, under a program approved by the Director, the provider has agreed to the lower amount.

2. Special applications. The following are examples of applications of the general rule; they are not all inclusive.

a. In the case of individual health care professionals and other noninstitutional providers, if the discounted fee is below the provider's normal billed charge and the prevailing charge level (see section G. of this chapter), the discounted fee shall be the provider's actual billed charge and the CHAMPUS allowable charge.

b. In the case of institutional providers normally paid on the basis of a pre-set amount (such as DRG-based amount under subsection A1. of this chapter or per-diem amount under subsection A.2. of this chapter), if the discount rate is lower than the pre-set rate, the discounted rate shall be the CHAMPUS-determined allowable cost. This is an exception to the usual rule that the pre-set rate is paid regardless of the institutional provider's billed charges or other factors.

3. Procedures.

a. This section only applies when both the provider and the Director have agreed to the discounted payment rate. The Director's agreement may be in the context of approval of a program that allows for such discounts.

b. The Director of OCHAMPUS may establish uniform terms, conditions and limitations for this payment method in order to avoid administrative complexity.

J. OUTSIDE THE UNITED STATES

The Director, OCHAMPUS, or a designee, shall determine the appropriate reimbursement method or methods to be used in the extension of CHAMPUS benefits for otherwise covered medical services or supplies provided by hospitals or other institutional providers, physicians or other individual professional providers, or other providers outside the United States.

K. IMPLEMENTING INSTRUCTIONS

The Director, OCHAMPUS, or a designee, shall issue CHAMPUS policies, instructions, procedures, and guidelines, as may be necessary to implement the intent of this chapter.